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8.9 Systematic but simple way to determine who needs residential care

Findings A US study has created a protocol to determine who to recommend for residential as opposed to non-residential rehabilitation. The *Client Matching Protocol* first identifies people excluded from one or other setting on practical or safety grounds ('exclusionary criteria'). Then allocation is based on problem severity ('clinical criteria'). The first version distilled current practice from nine centres offering a therapeutic community programme in both residential and non-residential settings. Piloting refined it down to the 30 questions in four 'domains' which best distinguished who would stay longer in one setting than the other. According to the protocol, residential care is only considered if the client's drug problem is relatively severe *and* stretches back at least four years without a break of a year or more. It is chosen if there are also either poor social indicators (crime or lacking a drug-free home or social circle) or poor employment prospects (lack of education, skills, training or experience).

Two sets of drug- and alcohol- dependent clients referred to the nine centres were allocated using normal procedures, but also completed the protocol. Its clinical criteria were tested on the 725 left after application of the exclusionary criteria. The 7 out of 10 allocated in line with the protocol ('matched' cases) did significantly better while in treatment than 'mismatched' cases. In the first set of patients nearly 20% more matched clients (47% v 28%) were still in treatment at follow up or had completed it and far fewer (10% v 28%) had to be discharged. The second set confirmed matching's retention/completion benefits. Rather than the individual domains, it was how they were combined in the protocol which made the difference. Matching was most important for moderately well motivated clients: those very highly or poorly motivated tended to do well or poorly irrespective of matching.

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In context That the protocol made a worthwhile difference is all the more remarkable since several factors worked against it. Most notably, it crystallised what can be expected to have been expert practice yet still bettered the uncrystallised starting point. Whether the criteria which emerged are duplicated elsewhere will depend on the range of problems in the caseload and the treatments on offer. If available, intensive non-residential programmes (but not routine outpatient care) may almost match residential care, even for severe cases. Several criteria seen in the study as precluding residential care seemed about what the services felt they could handle (or risk) in terms of medical need, transmissible disease, mental illness, and the potential for violence or suicide. These may have excluded the clients who might have gained most. For example, in one study suicide risk emerged as the key indicator for residential treatment.

Other studies generally confirm that only the more problematic clients especially benefit from residential care. As in the featured study, sometimes a constellation of factors (eg, severe psychiatric problems *plus* severe employment or family problems) seem decisive.

Practice implications There is a strong case for making the allocation criteria for different treatments explicit by systematising current practice and/or by drawing on relevant research. This protocol can then be refined in the light of experience (even if this is limited to progress in treatment and how it ends), providing a methodology for improving outcomes and cost-effectiveness. Factors indicative of residential care probably include severe drug abuse or dependence, psychiatric problems, lack of support for non-use (or non-problem use) in the home and in the client's family and social circles, homelessness, and the client's inability to support themselves in the community. How severe and multiple these problems need to be to justify residential care will depend partly on the intensity and adequacy of non-residential alternatives. Within the NTA's *Models of Care* framework these issues could form part of the comprehensive assessment for entry to tier 4a residential services. They have more research support than the criteria recommended in the framework.

Featured studies Melnick G. *et al*. "A client-treatment matching protocol for therapeutic communities: first report." *Journal of Substance Abuse Treatment*: 2001, 21, p. 119–128.

Contacts Gerald Melnick, National Development and Research Institutes, Inc, fax 00 1 212 845 4698, e-mail jerrymelnick@aol.com.

Extended text with references

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